**Health Care Provider Form**

Dear Health Care Provider, Your patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Participant’s Name) is interested in participating in supervised equine assisted activities. In order to safely provide this service, our center requests that you complete/update the attached Medical History and Physician’s Statement Form. Please note that the following conditions may suggest precautions and contraindications to equine activities. Therefore, when completing this form, please note whether these conditions are present and to what degree. Orthopedic: Atlantoaxial Instability- include neurological symptoms Coxa Arthrosis Cranial Deficits Heterotropic Ossification/Myositis Ossificans Joint Subluxation/Dislocation Pathologic Fractures Spinal Joint Fusion/Fixation Spinal Joint Instability/Abnormalities Neurologic Hydrocephalus/Shunt Seizure Spina Bifida/Chiari II Malformation/ Tethered Cord/ Hydromyelia Other: Indwelling Catheter/ Medical Equipment Medications- ie photosensitivity Poor Endurance Skin Breakdown Medical/Psychological: Allergies Animal Abuse Cardiac Condition Physical/Sexual/Emotional Abuse Blood Pressure Control Dangerous to Self or Others Exacerbations of Medical Conditions ( ie RA, MS) Fire Setting Hemophelia Medical Instability Migraines PVD Respiratory Conditions Recent Surgeries Thought Control Disorders Weight Control Disorder Thank you for your assistance. If you have any questions or concerns regarding this patient’s participation in Equine Assisted Activities, please feel free to contact us at the center or at the phone/address listed above.

Sincerely, Cati Christian, CLTFEHC Program Director

**PHYSICIAN’SSTATEMENT**
Participant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB: Click or tap to enter a date.Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Past/Prospective Surgeries:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Seizure: Y[ ]  N [ ] Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Controlled: Y[ ]  N[ ]
Date of Last Seizure: Click or tap to enter a date. Shunt Present: Y[ ]  N[ ]  Date of Last Revision: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Special Precautions/Needs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Mobility: Independent Ambulation Y[ ]  N[ ]  Assisted Ambulation: Y[ ]  N[ ]
Wheelchair: Y[ ]  N[ ]  Braces/Assistive Devices:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
For those with Down Syndrome: AtlantoDens Interval X-Rays, Date:Click or tap to enter a date. Result: \_\_\_\_\_\_\_\_\_ Neurologic Symptoms of AtlantoAxial
Instability: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes[ ]  No[ ]
Comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Please indicate current or past special needs in the following systems/areas. (Check All that Apply)
[ ] Auditory [ ] Visual [ ] Tactile Sensation [ ] Speech [ ] Cardiac [ ] Circulatory [ ] Integumentary/Skin [ ] Immunity [ ] Pulmonary [ ] Neurologic [ ] Muscular [ ] Balance [ ] Orthopedic [ ] Allergies [ ] Learning Disability [ ] Cognitive [ ] Emotional/Psychological Pain [ ] Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ To my knowledge there is no reason why this person cannot participate in supervised Equine Assisted Activities. However, I concur with a review of this person’s abilities/limitations by a licensed/credentialed health professional (e.g. OT, PT, SLP, Psychologist, etc) in the implementation of an effective equine assisted activity program.
Name/Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] MD, [ ] DO, [ ] NP, [ ] PA, [ ] Other: \_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:Click or tap to enter a date. Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
License/UPIN# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_@Choose an item.